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No. 84-1296

IN THE

Supreme Court of the United States

October Term, 1984

PENNSYLVANIA DENTAL ASSOCIATION; DELAWARE VALLEY DENTAL SOCIETY; ERIE COUNTY DENTAL ASSOCIATION, INC.; HARRISBURG AREA DENTAL SOCIETY; LUZERNE COUNTY DENTAL SOCIETY; MONTGOMERY-BUCKS DENTAL SOCIETY; ODONTOLOGICAL SOCIETY OF WESTERN PENNSYLVANIA; SCRANTON DENTAL SOCIETY; YORK COUNTY DENTAL SOCIETY; DENNIS W. KING, D.D.S.; CHARLES M. LUDWIG, D.D.S.; THEODORE R. PALADINO, D.D.S.; and THOMAS L. PERKINS, D.M.D.,

Petitioners,

v.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA, d/b/a PENNSYLVANIA BLUE SHIELD, and DONALD S. MAYES, D.D.S., IN HIS INDIVIDUAL CAPACITY,

Respondents.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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QUESTION PRESENTED

Whether this Court should decline to review the Third Circuit's affirmance of summary judgment as to Section 1 Sherman Act price-fixing claims regarding Pennsylvania Blue Shield's prepaid dental program where (i) the Petitioners have presented purely fact-bound issues without any significant supporting evidence and (ii) the Third Circuit's decision is in complete conformity with the applicable decisions of this Court and with the decisions of the other United States Courts of Appeals.

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Respondents.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

Pursuant to the authority of Rule 22 and in the manner provided by Rules 33 and 34 of the Supreme Court Rules, Medical Service Association of Pennsylvania, d/b/a Pennsylvania Blue Shield, and Donald S. Mayes, D.D.S., in his individual capacity, respond to the Petition of the Pennsylvania Dental Association, et al., and request that this Court deny the Petition on the basis of the facts and authorities hereinafter set forth for this Court's consideration.

I. STATUTORY PROVISIONS

Section 1 of the Sherman Act, 15 U.S.C. § 1, states in relevant part:

> "Every contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States . . . is hereby declared to be illegal."

II. COUNTERSTATEMENT OF THE CASE

The Petition for a Writ of Certiorari requests a third judicial analysis of the fact-bound issue of whether participating dentists, through majority membership on two advisory committees of Pennsylvania Blue Shield (PBS), have conspired to control aspects of PBS' dental insurance program to the competitive disadvantage of dentists who do not participate with PBS. Neither the United States Court of Appeals for the Third Circuit, in its opinion by Chief Judge Aldisert, nor the District Court found any factual basis to infer the existence of such a conspiracy. Furthermore, the Third Circuit's decision does not conflict with the decisions of this Court or any federal court of appeals, nor does this case present an important question of federal antitrust law not yet settled by this Court.

The fact-bound nature of the conspiracy issue presented by the Petitioners (PDA) is evident in the Third Circuit's holding that "[w]e reject appellants' theory of structural horizontal conspiracy because the uncontroverted facts furnish no support for it." Pet. App. 16a. The District Court's rejection of PDA's horizontal conspiracy argument was even more pointed: "The plaintiffs generally claim to be aggrieved and aver that foul play is afoot, but they have failed to present facts and a cogent theory which demonstrate these claims." Pet. App. 43a.

Because the principal issue presented in PDA's Petition is one of fact and because PBS believes that PDA's Statement does not adequately describe the facts relevant to the issue presented, the following undisputed facts concerning PBS' UCR dental program are presented.

PBS' prepaid UCR dental program at issue began in 1971 and involves contracts with participating dentists (pars) who agree to accept PBS' UCR payment allowance as payment in full for services to PBS subscribers. PBS also covers services provided by dentists who do not choose to contract with PBS (nonpars). Nonpars are free to "balance bill" their PBS subscriber patients for any difference between the UCR allowance and their own charges. PBS pays pars directly; payment for nonpar services is made to the subscriber, not to the nonpar.

Both PBS' provider and subscriber contracts provide that PBS' allowance for covered services shall be determined based upon a "usual, customary and reasonable" system which is commonly referred to as UCR. Under the UCR system every charge submitted by each dentist for services to PBS' subscribers is stored on a computer.

PBS' UCR payment allowance is determined in the same manner for all dentists regardless of participation status. Under UCR an individual "usual" charge (sometimes referred to as a "profile") is calculated by PBS for each dentist, for each procedure he performs, based on the actual charges he submits. PBS also calculates a "customary" charge for each procedure, for various specialty classifications of dentists, based upon the "usual" charges calculated by PBS for the dentists within the specialty grouping. PBS' payment allowance for each procedure submitted is

the lesser of the actual submitted charge, the dentist's individual "usual" charge or the applicable customary charge.[1] Individual dentists' profiles and customary levels are generally updated annually, except in those few instances where dentists have refused to verify their usual charges.

PBS' UCR system does not set "a maximum fee, minimum fee or any fee at all." Pet. App. 40a. PBS' reimbursement to a dentist is based on the fee actually and independently charged by the dentist. The dentist, not PBS, determines his fee. PBS' UCR system is predicated on the assumption that individual dentists do not vary their fees depending on whether the patient has insurance coverage and PBS requires that dentists certify on claim forms submitted to PBS that the fees listed thereon are the fees the dentist usually charges to his private, non-insured patients for the same services. J.A. 317, 320, 321, 372; D. Jones, M.D. Depo. at 156, Dist. Ct. Doc. No. 619. Obviously, if a dentist submits inflated fees to PBS, his usual charge will be inflated. Likewise, since customary charges are based on the "usual" charges calculated by PBS, the submission of inflated fees artificially increases PBS' customary charge allowance cap.

PBS' staff performs a variety of pre-treatment and post-treatment utilization review functions concerning services to its subscribers. One function particularly relevant to the instant issue is the in-office review (IOR). During the course of an IOR, PBS seeks to verify accuracy of

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[1] If unique or complex circumstances are involved in a particular situation, PBS may allow a charge in excess of the dentist's usual charge or the applicable customary charge. Such reasonability allowances are determined by PBS-employed dental advisors and are not at issue herein.

reporting and questions of over-utilization and mis-utilization of procedures. Also during an IOR, PBS seeks to verify the dentist's usual charge certifications to assure that the dentist has not charged inflated fees due to the presence of insurance coverage.[2]

PBS conducts IORs of both par and nonpar dentists in a uniform manner[3] and does not discriminate between par and nonpar dentists in selecting dentists to be reviewed or in acting upon its findings. IORs are conducted by members of PBS' staff.

If an IOR indicates a refund is due to PBS and if the dentist participates, PBS can collect the amount overpaid by offsetting against payments due to the dentist for other services. If the dentist is a nonpar, PBS cannot offset any amounts overpaid because nonpars do not receive direct payment from PBS. Since many dentists have vigorously resisted IORs it has not been uncommon for dentists to resign their participation status to thwart the conduct of an IOR or to effectively prevent PBS from recouping overpayments.[4]

From 1975 through the first half of 1982, PBS sought to verify the usual charges of 374 dentists by means of

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[2]PBS' subscriber agreements permit PBS to confirm all matters concerning covered care regardless of the participation status of the provider. Furthermore, PBS' Regulations for Participating Doctors permit PBS to examine par dentists' records. J.A. 320.

[3]The decision to conduct an IOR is made by PBS' staff. Such decision may result from subscriber complaints that a dentist's charge(s) increased when the subscriber first obtained PBS dental coverage. J.A. 1306-09.

[4]As described by the Third Circuit, Pet. App. 5a, there remains pending in the District Court PBS' Counterclaim against Petitioners which alleges, *inter alia*, a conspiracy in violation of Section 1 of the Sherman Act concerning deparcipation with PBS and impeding PBS' conduct of IORs.

IORs. During that period 32% of the dentists contacted refused to verify their usual charges and/or refused to permit PBS access to their offices. Of the dentists contacted who agreed to verify their usual charges, approximately one-half were found to have submitted inflated fees to PBS. J.A. 1351.

PBS' By-Laws provide that its business and affairs shall be managed by its Board of Directors and that one-half of its Board shall be lay persons. J.A. 1331. PBS' Board consists of 32 members: 16 lay persons and 16 doctors (only two of whom are dentists). Within PBS' corporate structure various standing committees of various composition exist to consider matters referred to them by the Board or management of PBS. The two committees at issue herein, the Dental Policy Committee and the Dental Review Committee, each have a majority of participating dentists as members. Committee members are appointed by the Chairman of PBS' Board in accordance with PBS' By-Laws. J.A. 1341-42. There is no basis for PDA's assertion that committee members are elected to represent "fellow par dentists".

III. REASONS FOR DENYING THE WRIT

1. The Issue Of Provider Control Presents A Question Of Fact Which Was Fully Analyzed And Correctly Decided By The Courts Below.

Each argument made by PDA in its Reasons For Granting the Writ assumes the existence of a factual predicate, i.e., provider control, contrary to the facts found by the courts below. Both the Third Circuit and the District Court specifically held that PDA presented no facts to support its horizontal conspiracy argument. Pet. App. 16a,

43a. Nonetheless, PDA mischaracterizes the Third Circuit's opinion as holding that "even where there is strong evidence that *de facto* control rests with the provider committees, the requirement of board ratification is sufficient to terminate any claim under section 1 of a conspiracy to restrain trade by injuring a competing group of providers." PDA Pet. 8.

The legal issue presented by PDA's Petition is a simple one and is clearly fact-bound: whether PBS' dental reimbursement system constitutes unilateral action or, instead, is the product of a conspiracy of par dentists who serve on certain PBS committees.[5] Chief Judge Aldisert's opinion clearly shows that the Third Circuit made a complete analysis of the committee actions at issue and correctly held that "(t)o give advice when asked by the decisionmaker is not equivalent to being the decisionmaker itself." Pet. App. 18a.[6]

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[5]The Federal Trade Commission recognizes that the ultimate issue of provider control "will be a question of fact in each particular case." Federal Trade Commission, *Enforcement Policy with Respect to Physician Agreements to Control Medical Prepayment Plans* (1981), 3 n.3 (1981).

[6]The Third Circuit noted that PDA's provider control argument "is dependent upon proof that participating dentists, through their majority membership on the two Blue Shield committees, actually controlled the establishment of the UCR system implemented by Blue Shield." Pet. App. 12a. Furthermore, the Third Circuit, after distinguishing the instant facts from those present in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), recognized that "(t)o the extent that Blue Shield's establishment of the UCR reimbursement system might disguise or embody an agreement among competing providers, its actions would come within the purview of § 1." Pet. App. 14a. However, contrary to PDA's assertions, the Third Circuit rejected PDA's provider control argument "*because the uncontroverted facts furnish no support for it.*" (Emphasis added.) Pet. App. 16a.

A. The Advisory Function of the Dental Policy Committee.

PDA's provider control argument about the Dental Policy Committee (DPC) is based on the undisputed fact that the DPC recommended to PBS' Board that PBS seek to allow at least 90% of aggregate charges submitted by all dentists. However, the undisputed facts surrounding the DPC's recommendation belie PDA's argument of delegation of pricing authority to the DPC. Moreover, there are no facts of record to support PDA's theory that the DPC was attempting to improve "the competitive position of pars *vis-a-vis* non-pars . . . by setting the differential at a figure large enough to create a significant incentive for patients to choose pars over non-pars" but not so large as to deprive pars of a profit for their services.[7] PDA Pet. 12.

PDA acknowledges that recommendations to an insurer by a group of providers concerning the insurer's treatment of competitors do not constitute a conspiracy with the insurer, PDA Pet. 14, and that technically the DPC "does not approve policies for the board, but merely makes recommendations to it." Pet. App. 16a. Furthermore, as noted by the Third Circuit, Pet. App. 17a, the DPC's recommendation that PBS seek "to allow at least 90% of aggregate charges" in the dental program was a goal "developed and urged by management." J.A. 1362. The minutes of the meeting of PBS' Board where it approved the DPC's recommendation as to allowing at least 90% of

[7]The minutes of the 1975 DPC meeting at issue clearly reflect that the DPC recommendation that a statewide geographic customary allowance charge class be retained in the dental program was management-inspired and premised on the lack of sufficient charge data to create additional valid geographic charge classes. The minutes do not mention participation status and no inference of a par dentist conspiracy can be reasonably drawn therefrom. J.A. 1280-84.

aggregate charges state that "this is the same position as taken by Management; the Dental Policy Committee is only agreeing to that position." Armitage Depo. Ex. 5 at p. 11, Dist. Ct. Doc. No. 898. No other evidence of DPC recommendations concerning payment allowances or treatment of dentists by participation status is cited by PDA in its Petition.

The Third Circuit's conclusion that the DPC's function was advisory only and was merely constituted and utilized as a resource to the Board is fully supported by uncontroverted facts of record.[8] In light of the lack of a par dentist majority on the Board (out of 32 directors, only two are dentists), the Third Circuit correctly concluded

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[8]Other adjustments to PBS' UCR system which had an effect on its dental program payout and which were neither recommended nor voted upon by the DPC include: (i) creation of an interim profile adjustment system which enables both pars and nonpars to obtain an interim update of "usual" charges if there had not been an increase in the prior two years, J.A. 1182-87; (ii) a change of the "usual" charge percentile from the 50th to the 75th percentile, which occurred in 1979, D. Jones, M.D. Depo. Ex. 14 at p. 348656-57, Dist. Ct. Doc. No. 619; R. Edmiston, M.D. Depo. Ex. 38 at p. 348557, Dist. Ct. Doc. No. 770; and (iii) use of charges reported in the first quarter of the current calendar year to determine "usual" charges, which occurred in 1981, J.A. 1210.

Furthermore, despite PDA's erroneous assertion, PDA Pet. 14-15, that the Board has "invariably" approved DPC recommendations, the uncontroverted facts prove otherwise. For example, nothing ever happened to the DPC's suggestion that the 90th percentile of a dentist's reported charges be used to calculate his "usual" charge for a specific procedure or that usual charges be updated every six months. J.A. 1282-84. Likewise, it is undisputed that the Board did *not* approve DPC's recommendation that payment be made for services to immediate family members under the dental program. Mann Depo. Ex. 36 at p. 13, Ex. 35 at p. 352281, Ex. 32 at p. 351821-351822, Dist. Ct. Doc. No. 736, and did *not* approve DPC's recommendation as to anesthesia coverage. Armitage Depo. Ex. 7, 16, 17, 18, Dist. Ct. Doc. No. 898.

that the 90% differential goal was not the product of a conspiracy of par dentists.

The Third Circuit's factual holding that PBS' Board, and not the DPC, controlled PBS' dental program and its holding that "[a]ction taken to find a market price so that a purchaser-insurer does not overpay does not constitute price-fixing", Pet. App. 17a, are consistent with traditional antitrust analysis and this Court's recognition in *Maricopa, supra,* that for an insurer to offer paid-in-full service benefit coverage someone must canvass providers "to determine what maximum prices would be high enough to attract sufficient numbers of individual doctors to sign up but low enough to make the insurance plan competitive." 457 U.S. at 353-54, n. 28. The facts that the 90% allowance goal was management-inspired and that the DPC only recommended the goal to PBS' Board show both the advisory nature of the recommendation and that such action was consistent with this Court's admonition in *Maricopa* that the insurer, and not the affected providers, should perform the canvassing.[9]

PDA quarrels with the Third Circuit's conclusion as to the DPC but offers no evidence, much less "strong" evidence, of *de facto* control by the DPC. Instead, PDA merely offers a conjectural theory unsupported by fact as to the asserted par dentist conspiracy. It is absolutely clear that the Third Circuit correctly determined the issue of DPC provider control and fully analyzed the DPC's role in rejecting PDA's par dentist conspiracy theory.

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[9]It should also be noted that PBS' UCR system does not involve any agreement by providers to charge a set fee, as was the case in *Maricopa*. The UCR system is based on providers' *personally determined charges* and the effect thereof is that a dentist is paid his personally determined, most frequently submitted charge for his services unless that charge exceeds the applicable customary level.

B. The Dental Review Committee And The Withholding Of Profile Updates Of Dentists Who Are Suspected Of Improperly Overcharging Blue Shield.

PDA's argument about the Dental Review Committee (DRC) consists of unsupported supposition and irrelevant references to "peer review" functions of professional societies. At issue is the authority of the DRC to prohibit profile updates of dentists who are reasonably suspected of improperly overcharging PBS by the submission of inflated charges because of the presence of insurance coverage. Although the DRC initially recommended such sanction, the record is clear that the authority to prohibit profile updates was not granted to the DRC, nor were profile updates withheld, until the authority was recommended by another PBS non-dentist committee and conferred upon the DRC by PBS' Board.[10]

As early as 1976, PBS' in-office review (IOR) experience had demonstrated that many dentists were charging their PBS subscriber patients higher rates than their non-insured patients. Such activity threatened the integrity of PBS' UCR system, which is predicated on the assumption that providers do not increase their fees because of the presence of insurance. By 1979 it was apparent that the magnitude of the problem could not be ascertained because PBS could not compel nonpars to verify their usual charges and because many pars resigned their par status to thwart PBS' verification process. Furthermore, it

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[10]Such fact clearly refutes PDA's assertion that it is an open question whether PBS' Board made an independent decision with respect to the DRC's profile update recommendation. (PDA Pet. 19).

was apparent that in many instances PBS could not recoup overpayments cost-effectively.[11]

The members of the DRC became aware of the inflated fee verification problem during DRC meetings.[12] In November, 1979 the DRC recommended that PBS consider withholding profile updates of dentists who refused to verify their usual charges and asked that the matter be referred to "the appropriate Committee of the Board of Directors for policy consideration." J.A. 1461. Ultimately, after the recommendation was approved by PBS' eleven member Professional Relations Committee (only one of whom was a dentist), J.A. 1316; D. Jones, M.D. Depo. Ex. 18, 19, Dist. Ct. Doc. No. 620, on May 2, 1980 PBS' Board authorized the DRC to prohibit the update of profiles of *dentists* who refuse to verify that their fees to PBS are the fees they usually charge to non-insured patients. H. Armitage, M.D. Depo. Ex. 14 at p. 348842, Dist. Ct. Doc. No. 898.

Contrary to PDA's erroneous suggestion, no profile updates were withheld by PBS until the Board authorized

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[11]From 1975 through the first half of 1982, PBS sought to verify the usual charges of 374 dentists by means of IORs. During that period, 119 (31.8%) of the dentists contacted refused to verify their usual charges and/or refused to permit PBS access to their offices, 121 (32.4%) of the dentists contacted agreed to the verification and inflated charge problems in their billing practices were found, and 134 (35.8%) of the dentists contacted agreed to the verification and no inflated charge problems were found. J.A. 1351. PBS' difficulty in recouping overpayments was caused by the facts that many par dentists resigned their status when presented with an IOR or refund request, many nonpar dentists refused IOR requests and PBS is unable to offset overpayments as to nonpar dentists.

[12]The result of each IOR conducted and the status of each IOR requested by PBS' staff are presented to the DRC. Furthermore, the ethics of the dental profession condemn the charging of inflated fees because of insurance coverage. J.A. 773-75, 718, 722.

such action. J.A. 1311-12, 1347. Furthermore, the authority granted to the DRC was limited to the specific situation where a dentist refused to verify his usual charges, rather than "whenever the committee deemed it appropriate", as erroneously represented by PDA. PDA Pet. 18-19. Following Board authorization, the DRC has consistently prohibited profile updates of dentists who refuse to verify their usual charges.[13]

Four undisputed facts surrounding the grant of authority to the DRC to prohibit profile updates convinced the Third Circuit, Pet. App. 17a, that the DRC did not participate in price-fixing and readily demonstrate that the DRC's activity does not create a factual issue as to § 1 Sherman Act concerted action: (i) PBS' requirement that dentists not inflate their charges to PBS is consistent with the ethics of the dental profession, J.A. 773-75, 718, 722; (ii) PBS' IOR experience showed that about one-half of the dentists who agreed to verification had charged inflated fees and that about one-third of the dentists contacted refused to verify their usual charges, J.A. 1354; (iii) the Pennsylvania Department of Health approved the concept of PBS verifying dentists' usual charges by means of IORs, J.A. 1320-22;[14] and (iv) profile updates were not withheld

[13]Through the end of 1982 only approximately 85 dentists had been denied profile updates and subsequent to their agreement to verify usual charges, profile updates have been granted to 15 out of the 85 dentists. All of such profile update denials have occurred because of a refusal to verify usual charges. Furthermore, PBS' withholding of profile updates does not "freeze the fees" of the affected dentists but merely affects PBS' payment allowance. J.A. 1317-18, 1584.

[14]PDA erroneously suggests that the Third Circuit's holding as to the DRC is based in part on "state action" grounds. PDA Pet. 21. However, state approval of PBS' efforts to assure that its payments for dental services do not exceed its contractual obligations undercuts PDA's specious argument that denial of profile updates was motivated

(Continued on next page)

until both a non-dentist committee and PBS' Board authorized such action. J.A. 1311-12, 1347. In light of the foregoing, there is no basis for an inference that action taken to preclude fraudulent billing practices, which inures to the benefit of PBS (and therefore ultimately to its consumers) and which was authorized by PBS' Board demonstrates either provider control or price fixing.

The undisputed facts also belie PDA's transparent assertions as to the possible competitive consequences of DRC's denial of profile updates. The sanction has not been imposed because the DRC believes any dentist's fees are too high, as was alleged in *Ratino v. Medical Service of D.C.*, 718 F.2d 1260 (4th Cir. 1983) or too low, but is imposed only if a dentist refuses to substantiate that he has not been improperly overcharging PBS. Any dentist who is being denied a profile update can obtain one simply by substantiating his usual charges. Furthermore, contrary to PDA's assertions, there is no evidence of record that any dentist who has been denied a profile update competes with any member, past or present, of the DRC.

Likewise, the fact that profile updates have been denied to both par and nonpar dentists, J.A. 769-70, renders nugatory PDA's theory that the alleged conspiracy is one of par dentists to obtain a competitive advantage over nonpar dentists. Similarly, the fact that authority to deny profile updates only concerned dentists and that corresponding authority to prohibit profile updates of physicians was not granted to PBS' Medical Review Committee

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(Continued)
by a desire to confer a competitive advantage on any category of dentists.

militates against PDA's vague reference to an overall participating provider conspiracy against nonparticipating providers.[15]

Finally, PDA's assertion that the Third Circuit's analysis of the DRC would undermine any criterion proposed by the FTC to ensure that anticompetitive risks do not arise in peer review activities is irrelevant to the instant issue. The DRC's activities constitute "peer review" in only the broadest sense of the term and are inapposite to the peer review functions addressed by the FTC in its advisory opinions cited by PDA. The DRC does not address the reasonableness of any dentist's fee, nor is the sanction of denial of profile updates imposed because any fee or fees are considered to be too high or too low. Furthermore, the DRC only considers matters concerning a dentist's relations with PBS. J.A. 1335-38.

The orderly corporate process by which PBS' Board authorized the DRC to deny profile updates clearly shows that the DRC's authorization is not the product of a conspiracy of par dentists. The fact that the DRC's power is limited to the specific situation where a dentist refuses to substantiate that he is not improperly overcharging PBS demonstrates the legitimacy of the sanction. The sanction imposed only affects what PBS will pay for services, not what any dentist may charge. Therefore, the Third Circuit correctly held that the DRC has not "engaged in conduct that runs afoul of the antitrust laws." PDA App. 18a.

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[15]Corresponding power was not granted to PBS' Medical Review Committee because the problem of usual charge verification appeared to be limited to the dental area. J.A. 1236.

2. The Decision of the Third Circuit is Consistent with the Decisions of this Court and of the Circuit Courts of Appeals.

PDA's Petition alleges the existence of a conspiracy of par dentists to effect and enforce a 10% differential between aggregate charges submitted in PBS' dental program and PBS' aggregate payment for dental services.[16] The conspiracy is unsupported by the facts of record. Moreover, analysis of PDA's illusory assertions of the anticompetitive effects that are "very likely" to be caused thereby demonstrates that the Third Circuit's decision does not conflict with any decision of this Court or of any federal court of appeals.

PDA's argument that the cap on the UCR allowance may injure PBS by causing subscribers who are loyal to nonpars to switch dental insurers, PDA Pet. 13 n. 14, presents a practical impossibility because, as PDA acknowledges, PBS only markets *group* dental coverage

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[16]PDA vaguely suggests two other possible conspiracy theories: (i) a conspiracy of DRC members to obtain a competitive advantage over those few dentists who have been denied profile updates because they refuse to substantiate that they are not improperly overcharging PBS because of the presence of insurance coverage, PDA Pet. 19-20, and (ii) an overall conspiracy of all participating providers. The DRC theory fails because there is no proof of a competitive relationship between any DRC member and any dentist denied a profile update and by the circumstances surrounding profile update denials. The overall participating provider theory is an obvious afterthought. The PDA did not raise such a conspiracy theory before the Third Circuit and the Third Circuit did not address it. For this reason alone this Court should decline to address it. *Monsanto Co. v. Spray-Rite Service Corp.*, ____ U.S. ____, 104 S.Ct. 1464, 1468-69, n.6 (1984). In any event, there is no evidence of record of such a conspiracy and there is no dispute that during the time period in question (1975) PBS was compelled by state statute to have a provider majority on its Board. Act of Nov. 15, 1972, P.L. 1063, No. 271, § 6328, formerly codified at 40 P.S. § 6328.

and individual subscribers lack the prerogative of choosing a dental insurer. Likewise, PDA's assertion that if PBS paid 100% of dentists' charges, patients would have no incentive to choose pars over nonpars directly contradicts PDA's repeated assertions in the courts below that PBS' policy of making direct payment to only pars causes PBS subscribers to boycott nonpar dentists. PDA Reply Brief to Third Circuit, 16, 17; PDA Brief to Third Circuit 38-40; PDA Brief in Opposition to Summary Judgment 17, 72.

The undisputed fact that the DRC's denial of profile updates affects both pars and nonpars directly contradicts PDA's explanation of the DRC's role in its par dentist conspiracy theory as "improving the competitive position of par dentists." PDA Pet. 19.

When PDA's illusory conspiracy assertions are compared to the undisputed facts of record it is clear that the courts below correctly determined that PDA's par dentist conspiracy theory is purely speculative and without factual support.[17] Furthermore, it is clear that the true nature of PDA's complaints is about the pro-competitive pressures presented by PBS' dental program. As noted by PDA, PDA Pet. 7-8, the FTC has conducted investigations of the question of physician (not dentist) control of Blue Shield plans which culminated in staff reports recommending industry-wide rulemaking by the FTC. However, the FTC rejected the need for industry-wide rulemaking, *see* Advance Notice of Proposed Rulemaking, 45 Fed. Reg. 17,019, 17,022-23 n.2 (1980), and instead determined to approach

[17] It should be noted that, as found by the District Court: "it is not testimonial evidence that PDA relies upon to establish and advance its 'conspiracy mechanism' argument. PDA does not point to conspiratorial conversations, the testimony of Blue Shield insiders or participating dentists to establish its conspiracy theory." Pet. App. 40a-41a.

the issue on a case-by-case basis to avoid discouraging pro-competitive prepayment programs. Federal Trade Commission, *Enforcement Policy with Respect to Physician Agreements to Control Medical Prepayment Plans* (1981), p. 3-4.

To paraphrase the Seventh Circuit's opinion in *Quality Auto Body, Inc. v. Allstate Insurance Co.*, 660 F.2d 1195, at 1206 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982), the gravamen of PDA's complaint is PBS' refusal to pay more than a competitive price for dental services. The pro-competitive aspects of a Blue Shield or Blue Cross plan computing its reimbursement allowance based upon the prevailing competitive price in the marketplace have been recognized by numerous courts. *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F.2d 922 (1st Cir. 1984); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.*, 675 F.2d 502 (2d Cir. 1982); *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973).

There is no dispute that PBS' UCR dental program creates an incentive for subscribers to patronize par dentists and that all Pennsylvania dentists are free to participate with PBS. Therefore, if a nonpar dentist refuses to meet the price competition created by PBS and thereby loses patients, whatever injury he suffers is not cognizable under the antitrust laws because the injury results from increased rather than reduced competition. *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 489 (1977); *Travelers Ins. Co., supra.; Klamath-Lake Pharmaceutical Association v. Klamath Medical Service Bureau*, 701 F.2d 1276 (9th Cir.), *cert. denied*, ____ U.S. ____, 104 S.Ct. 88 (1983). Likewise, dentists, par or nonpar, who

receive less for services to PBS subscribers than they do from their non-insured patients do not suffer antitrust injury. *Medical Arts Pharmacy, supra,* 675 F.2d at 507 ("A low profit margin on sales to Blue Cross subscribers could not, however, establish an antitrust violation under the rule of reason."); *Sausalito Pharmacy, Inc. v. Blue Shield of California,* 544 F.Supp. 230, 235 (N.D.Cal. 1981), *aff'd per curiam,* 677 F.2d 47 (9th Cir.), *cert. denied,* 459 U.S. 1016 (1982) ("The failure to make more money . . . is simply not the kind of problem which the antitrust laws address.").

It is clear that the courts below did not ignore this Court's cautionary language about use of summary procedures in antitrust litigation in *Poller v. Columbia Broadcasting System, Inc.,* 368 U.S. 464, at 473 (1962)[18] and that the Third Circuit's decision does not conflict with the decisions of any federal court of appeals.

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[18]Although antitrust attacks on contracts between insurers and providers have intensified in recent years, numerous courts have upheld the legality of such provider agreements on motions for summary judgment. *Klamath-Lake Pharmaceutical Association v. Klamath Medical Service Bureau,* 701 F.2d 1276 (9th Cir.) *cert. denied,* _____ U.S. _____, 104 S.Ct. 88 (1983); *Sausalito Pharmacy, Inc. v. Blue Shield of California,* 544 F.Supp. 230 (N.D.Cal. 1981), *aff'd per curiam,* 677 F.2d 47 (9th Cir.), *cert. denied,* 459 U.S. 1016 (1982); *Quality Auto Body, Inc. v. Allstate Insurance Co.,* 660 F.2d 1195 (7th Cir. 1981), *cert. denied,* 455 U.S. 1020 (1982); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.,* 518 F.Supp. 1100 (D.Conn. 1981), *aff'd,* 675 F.2d 502 (2d Cir. 1982); *Human Resource Institute of Norfolk, Inc. v. Blue Cross of Virginia,* 498 F.Supp. 63 (E.D.Va. 1980); *Blue Cross and Blue Shield of Michigan v. Michigan Association of Psychotherapy Clinics,* 1980-2 Trade Cases ¶ 63,351 (E.D.Mich. 1980); *Davidowitz v. San Diego County Dental Society,* 1983-1 Trade Cases ¶ 65,231 (S.D.Cal. 1983), *denying reconsideration,* 1984-1 Trade Cases ¶ 65,988 (S.D.Cal. 1984).

These cases indicate a judicial consensus that antitrust challenges to provider agreements do not ordinarily present genuine issues of material fact which would preclude a grant of summary judgment.

The foregoing discussion of the pro-competitive effects of PBS' dental program dispels any notion that the Third Circuit failed to analyze PDA's complaints under the rule of reason. Furthermore, PDA's references to *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981); *Glen Eden Hospital, Inc. v. Blue Cross and Blue Shield of Michigan, Inc.*, 740 F.2d 423 (6th Cir. 1984); *St. Bernard General Hospital v. Hospital Service Association of New Orleans, Inc.*, 712 F.2d 978 (5th Cir. 1983), *cert. denied*, ____ U.S. ____, 104 S.Ct. 2342 (1984); and *Ratino v. Medical Service of D.C.*, 718 F.2d 1260 (4th Cir. 1983) do not demonstrate a split in circuits on the provider control issue because those cases are both legally and factually distinguishable from the instant case.

The PDA Petition does not allege a conspiracy by one discipline of provider to preclude another discipline from obtaining reimbursement from an insurer, as was presented in *Virginia Academy*. Furthermore, *Virginia Academy* is also distinguishable because therein provider control was based on board composition plus abundant other evidence.[19]

St. Bernard Hospital and *Glen Eden* are also clearly distinguishable because in both cases the alleged conspiracies consisted of participating providers causing insurers to reimburse all non-participating providers at lesser rates. In the instant case the conspiracy alleged by PDA is one to lower PBS' payment allowance to both par and nonpar

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[19] *Virginia Academy* should be contrasted with *Human Resource Institute of Norfolk, Inc. v. Blue Cross of Virginia*, 498 F.Supp. 63 (E.D.Va. 1980) wherein the court applied the Fourth Circuit's "walking conspiracy" theory and found no provider control because the insurer's board did not consist of a provider majority and *no direct evidence* of provider control of the insurer by other means was presented.

dentists. In *St. Bernard Hospital,* representatives of participating hospitals comprised a super-majority of the insurer's board of directors as distinguished from the instant case where only two members of PBS' 32-member board are dentists. *Glen Eden* is also further distinguishable, as recognized by the Third Circuit, Pet. App. 15a, because the plaintiff was allowed only severely limited discovery on the provider control issue.

Ratino is similarly distinguishable because the Fourth Circuit merely reversed the district court's grant of summary judgment on the, by then, eroded grounds of the McCarran-Ferguson Act business of insurance exemption. Moreover, PDA's reference to *Ratino's* discussion of the peer review function is factually inapposite because in *Ratino* a binding peer review determination of the reasonableness of an individual doctor's fees was at issue.

In the final analysis, PDA seeks this Court's review of the factual determination of two fact finders which both reached the same conclusion that PDA's provider control conspiracy argument is without factual support. There is no reason for this Court to review the fact-bound decision of the Third Circuit. PDA's Petition is without merit and it is clear that PDA is merely seeking, in the words of the District Court, "the opportunity . . . to pursue their case in search of its existence." Pet. App. 56a.

IV. CONCLUSION

The Petition For A Writ of Certiorari should be denied.

Respectfully submitted,

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RULE 28.1 CERTIFICATE

Respondent Medical Service Association of Pennsylvania d/b/a Pennsylvania Blue Shield respectfully advises the Court pursuant to Rule 28.1 of the Rules of this Court that it has no parent and that it owns stock in the following subsidiaries (except wholly-owned subsidiaries) or affiliates: Camp Hill Insurance Company.